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Doing comparison: producing authority in an international organization

Richard Freeman and Steve Sturdy

University of Edinburgh

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International comparison is one of the principal ways in which national governments nowadays seek to assess and improve the effectiveness of their policies, from delivery of services such as education and healthcare, to control of social issues such as crime and migration, to administrative functions such as tax collection. International organisations such as OECD and WHO have benefited from this turn to comparison, positioning themselves as authoritative producers of comparative data for policy purposes. Their success in achieving and sustaining this position owes much to their development of standardised and especially quantitative methods of data collection, analysis and publication, often in the form of easy-to-read tabulations and digests. The result is an international policy regime in which comparative data, and the international organisations that produce them, increasingly serve as key points of reference against which national policies must be measured and evaluated.

At the same time, however, many academics in the fields of political science and policy studies have become increasingly sceptical about just how meaningful or informative such standardised comparisons of national policies can actually be. Whereas during the 1970s and 1980s political scientists were keen to embrace the aims of standardised comparison as a supposedly 'scientific' means of identifying successful policies,¹ subsequent empirical studies have increasingly highlighted the context-dependency of evaluation and the cultural specificity of policy and its meanings. While the academic impulse to comparison has by no means diminished, the purpose has increasingly shifted away from standardised measurement of effectiveness, towards a much more holistic, inductive and multi-dimensional appreciation of the similarities and differences between different national policy cultures.²

Seen in this light, the increasingly widespread use of standardised comparison by national and international policy bodies poses something of a conundrum: if the lessons that can be drawn from such comparisons are, strictly speaking, of limited significance, then what are policy bodies doing when they do comparison?

This chapter offers an answer by looking at comparison, not simply as a means of generating policy-relevant knowledge, but as itself a form of policy work. Based on an empirical study of the various initiatives through which, since the 1970s, the staff of the European Regional Office of the WHO have sought to learn about—and ultimately to reform—the provision of mental health services in different member countries, we offer an analysis of the rather different ways in which comparison may

be conducted in a policy setting. In particular, we emphasise the central role that knowledge of particular cases—in this instance, cases of local or national mental health provision—plays in the work of comparison. In so doing, we discard the assumption, implicit in much of the literature on “knowledge and policy”, that knowledge and policy can somehow be treated as distinct from one another. As Annabelle Littoz-Monnet observes in the introduction of this volume, writers in this field commonly tend to ask either how knowledge impacts on policymaking, or how policy interests shape the production or deployment of knowledge.³ But WHO Europe’s comparative studies of mental health transcended this distinction. Our view of the relationship between knowledge and policy is thus much closer to Sheila Jasanoff’s account of “co-production” in its recognition that policy is a form of knowledgeable action, and the production of policy knowledge is itself a way doing policy.⁴

We begin by introducing WHO Europe’s developing interest in mental health – one of the ways in which the Europe office sought to define a distinctive role for itself within WHO more generally – and we examine the ways it sought to find out about different patterns of policy and service provision in different countries. We show how observers sometimes began with cases in order to identify appropriate axes of comparison; and sometimes by defining standardised comparative schemata that they then tried to apply to the cases under their purview. These different ways of knowing tend to be associated with two different styles of policy-making and implementation: bottom-up, based in local knowledge of what will and will not work locally; and top-down, based in centralised efforts to specify what action to take locally. By following the different ways in which WHO has sought to produce comparative knowledge of

mental health provision, we thus also shed light on the different ways it has endeavoured to configure itself as an authoritative policy organisation.

Significantly, both local case studies and cross-national surveys are produced in interaction among policy makers in different countries and WHO officers. They are generated iteratively, in a process of consultation and negotiation among experts as they learn how to create authoritative understandings of the world in which they work. In concluding, we show how the work of comparing may itself serve to make cases more comparable. In this sense, comparison is performative, and the imposition of strict criteria of comparison becomes a means of promoting the convergence or alignment of the various cases being compared.

WHO and mental health in Europe⁵

Established in 1948 as part of the UN system, WHO quickly incorporated mental health into its scope of interest. A Mental Health Unit was established at WHO Headquarters in 1948 and an Expert Committee on Mental Health met for the first time in 1949. Reviewing its activities in the sphere of mental health in 1962, WHO also discussed a number of study groups, conferences, consultants, meetings and reports that had been undertaken or were under way at that time.⁶ Additional study groups, seminars and conferences were organized jointly with other bodies, both governmental and non-governmental, including the World Federation for Mental Health, as well as ILO, UNESCO and other UN agencies. The primary function of all these activities was to promote communication with "representatives of developing countries in need of information on mental health" and/or discussion with "non-

psychiatrists."⁷ From the start, then, WHO's work around mental health was centrally concerned with ensuring a flow of expert opinion and information across national boundaries.

Mental health was of particular interest to WHO's Regional Office in Europe – in part because Europe was less affected by the infectious diseases that preoccupied other WHO regional offices, and saw mental health as presenting a distinctive challenge to tackle.⁸ In September 1970, its Regional Committee formally approved a "long-term programme" in mental health which ran until 1982, since when WHO Europe's work on mental health has been differentiated into more specifically defined projects. Responsibility for leading these activities has been vested, since the early 1970s, in a succession of Regional Advisers for Mental Health. From the beginning, WHO Europe's activities in the field of mental health have been marked by a strong commitment to promote community mental health alongside more institutionally-centred forms of psychiatric care.⁹

Central to WHO Europe's efforts to reform mental health services across the region has been the collection and circulation of information about the state of those services in member countries. These activities can be divided into two parallel strands. First, from the initiation of the "long-term programme" onwards, Regional Advisers for Mental Health have taken a recurring interest in conducting systematic surveys with the aim of comparing mental health service provision in different countries, and ultimately of identifying what kinds of provision are most effective in securing good mental health. Such surveys have repeatedly run into difficulties, however. The first Regional Adviser, Tony May, circulated a standard questionnaire to each of the thirty

countries in the region. His aim was explicitly "to identify developments in particular countries which could be useful for the Region as a whole."¹⁰ However, the returns were vitiated by gaps in the data, and by a lack of consistent criteria and terminology of reporting, precluding any possibility of rigorous comparative analysis.¹¹ May's successor, John Henderson, adopted a more pragmatic approach during the early 1980s, eschewing direct measurement of mental health impact in favour of "general 'indicators' of progress in mental illness care" of a kind that seemed "susceptible to measurement in terms of the accessible information"—for instance, reduction in "the number of mental hospitals with more than 1000 beds."¹² Even these data proved difficult to collect and interpret in any standardised way, however, and Henderson concluded that they permitted only the most limited comparison between different countries.¹³

Later in the 1980s, WHO central office in Geneva launched an initiative to establish a new survey tool, published in 1996 as the International Classification of Mental Health Care (ICMHC). In practice, the ICMHC offered a sophisticated tool for conducting in-depth comparisons of relatively similar services, but it proved unwieldy as a tool for surveying mental health provision more widely.¹⁴ WHO Europe attempted no further systematic surveys of mental health provision until the mid-2000s, when it developed yet another questionnaire, based not on the ICMHC but on the rather simpler Assessment Instrument for Mental Health Systems (AIMHS), developed by WHO in Geneva to identify and assess the main components of mental health systems in low and middle-income countries.¹⁵ This 'Baseline Survey', as it became known, generated a vast amount of data from a total of forty-two participating countries. But despite considerable care in drawing up the questionnaire, the results

again defied systematic comparison, especially in Western Europe, where de-institutionalisation and diversification of mental health services had progressed furthest; here, the report concluded, services "appear to be so differentiated that any comparison is haphazard".¹⁶

In parallel with efforts to undertake a comprehensive survey of mental health provision, WHO Europe also pursued a second approach to eliciting and circulating information about the state of mental health services in member countries. In 1973, the first Regional Adviser, Tony May, initiated a programme of in-depth investigations into a series of planned innovations and "experimental services" in Trieste, Mannheim, Stockholm and Leningrad, as well as new initiatives in care for subgroups.¹⁷ Starting with nine such experiments, by the mid-1980s the programme had expanded to comprise a total of twenty-one so-called "pilot study areas" distributed across sixteen member countries.¹⁸ In contrast to WHO Europe's efforts to undertake systematic surveys of mental health provision in different countries, the pilot study areas programme was not intended to be strictly comparative. Rather than providing a synoptic view of "national trends" in mental health provision, it set out to document "a number of selected local experiments which might serve as demonstration models for future development".¹⁹ May and his successors as Regional Adviser anticipated that the pilot area studies would still lead to improvements in provision in other countries; but they would do so, not by demonstrating the comparative advantages and deficiencies of different national systems, but by providing a number of exemplary cases of good practice that policy makers and mental health practitioners elsewhere might seek to emulate.

Like WHO Europe's repeated efforts to conduct systematic surveys, this case-based approach to knowing about mental health provision in different national or local setting recurs repeatedly in WHO Europe's activities. In the late 1990s, for instance, the then Regional Adviser Wolfgang Rutz established a system of so-called national "counterparts", nominated by national health ministries and responsible for liaison with WHO in respect of mental health. Among other activities, the counterparts were expected to bring to the table their personal knowledge of provision in their respective countries. In 2001, for instance, they contributed a series of short "country reports" to that year's World Health Report. Eschewing any attempt at explicit international comparison, these country reports were expected to be "unpretentious and informative", providing "an impressionistic review describing the relevant efforts and shortcomings as experienced by the counterpart".²⁰

This approach to case-based knowledge-sharing, based in personal, often highly-detailed knowledge of local developments, was particularly prominent in the events surrounding the WHO European Ministerial Conference on Mental Health, held in Helsinki in January 2005. The centrepiece of this conference was the approval and publication of two key policy documents: the Mental Health Declaration for Europe and the Mental Health Action Plan for Europe.²¹ These were pitched at a very high level of generality: while the Declaration was largely devoted to reasserting WHO's long-standing commitment to community mental health, the Action Plan identified twelve "challenges" on the way to achieving that goal, and listed a wide range of "actions to consider" as means of addressing those challenges. Neither document provided any empirical evidence in support of the public mental health perspective or the particular lines of action that they recommended; rather, they read more like a

statement of shared aims and values than an example of evidence-based policy. However, the Declaration and Action Plan were supported by a series of fourteen "briefing papers" covering a range of topics, including the mental health of children and young people, stigma and social exclusion, and suicide prevention. These papers provided a certain amount of statistical evidence on the epidemiology of different conditions and the availability of psychiatric and other kinds of mental health care across Europe. They also provided short qualitative case studies of the nature and content of particular mental health initiatives under way in different countries. Like the pilot study areas, these were intended to be taken as exemplary cases of good practice, to be emulated or at least reflected on as policy makers sought to follow the guidance set out in the Mental Health Action Plan.

At first glance, these two approaches to building and sharing knowledge of good mental health practice—one based on surveys, the other based on in-depth knowledge of particular cases of good practice—appear quite distinct. The former is clearly comparative in intent, aiming to produce rigorous cross-national comparison of mental health provision, and of how effective such provision might be in delivering good mental health; while the latter appears to eschew comparison in favour of local 'experiments' in service provision. At first sight, it might seem that there are two quite different, even incommensurable epistemologies in play here: one scientific in its appeal to universal standards of observation; the other holistic and intuitive in its attention to the peculiarities of individual cases. On closer analysis, however, the distinction between the two approaches becomes less marked, and the continuities more apparent; rather than different epistemologies, we might better regard them as involving different 'ways of knowing'. Our separation of them here is simply

heuristic; in reality, they are closely intertwined, evolving in a back-and-forth movement from one to the other as different actors seek practical solutions to what we might term the 'problem of comparison'. What is at stake here is not so much the possibility of comparison, but rather the form it might take, and the ends it might serve.

Working with cases

Let us start with the case-based approach to knowing about policy. Knowledge of cases, according to a long philosophical tradition, typically involves attending to what is particular, peculiar or idiosyncratic about those cases. But appreciation of the particularities of any given case is necessarily a comparative exercise: in order to know what is different about a case, we need to compare it to other cases. Nor are comparator cases usually chosen at random; rather, they tend to be selected because they are in some relevant way similar to the case under consideration. In other words, knowledge of a case necessarily involves understanding both how it resembles and how it differs from other cases; it depends, implicitly if not explicitly, on comparison with other cases.

This is evident if we consider the mental health initiatives selected for investigation under WHO Europe's pilot study areas programme. However different those initiatives might have been, all were judged to be similar at least insofar as they were all instances of mental health provision. Additionally, all were expected "to attempt to define adequate and acceptable services, and to describe and evaluate the patterns of operational practice in the areas."²² The whole point of selecting and studying these

cases was to identify particular forms of provision or practice that had been established in one setting that could usefully be copied or adapted in another. The purpose of the pilot study areas programme, in other words, was to bring together a series of cases that could instructively be compared with one another and with prevailing models of mental health provision elsewhere, so that investigators, policy makers and practitioners could draw useful lessons about how to pursue the goals of mental health reform more generally.

However, the architects of the pilot study areas scheme made no explicit recommendations for how comparison should proceed. One of the key priorities was to get as full an appreciation as possible of "the nuances and subtleties of administration, organization and function that give each service its unique character."²³ The investigators were well aware that such detailed knowledge of particular cases could make systematic comparison harder rather than easier: "With such a wealth of data, and with the range of human experience encompassed by mental health services, it is not surprising that general, overall comparisons of areas were found impossible."²⁴ The more one knew about particular cases, the greater the range of possible points of similarity and difference between them. Mental health professionals and policy makers seeking to learn from these cases thus faced the challenge of deciding what aspects of any given case were likely to be most relevant: not only what measures or initiatives seemed to work in their original setting, but also what might be transferrable into some other, different mental health system. Moreover, the lessons to be learned from any particular case were not necessarily self-evident; they had to be identified through careful consideration and evaluation of all the complexities of the case at hand, and all the ways it resembled and differed

from other cases. In effect, the whole process of comparing cases was under-determined and open-ended, and proceeded inductively on a case-by-case basis.

This had implications for how the work of comparing and learning from the different pilot study areas could best be organised. Consideration of just what aspects of any given case might or might not be salient or informative for developments elsewhere required an intimate understanding of that case in all its complexity, of a kind that could only really be achieved through direct personal experience. As one participant observed, "The only way to get to know how a psychiatric service functions is to work in it for a period of time."²⁵ In order to explore and compare cases in the kind of detail required, it was therefore necessary to bring together the people who embodied the requisite experience. A review of the development of the pilot study areas project observed that "An important feature of the project was the regular, approximately annual meetings of the pilot study area directors and/or their representatives and collaborators, where the usefulness and further development of the instruments was discussed." These meetings provided "an important forum for the exchange of information about psychiatric care under greatly varying sociocultural and economic conditions, largely inexpressible in statistical terms."²⁶ In effect, they were the venue for a process of collective exploration, through which the participants identified meaningful similarities and differences between their respective cases, and looked for ideas and practices that they could usefully incorporate into their own systems of mental health provision.

This process of collective comparison and learning was productive in that it led to real improvements in mental health provision, both within the study areas themselves and

elsewhere.²⁷ In that sense, the pilot study area programme proved to be an effective instrument for WHO Europe to pursue its policy goals. It represented a non-authoritarian approach to policy, however—as is apparent if we consider how relations between the various participants changed in the course of the programme. Initially, WHO officers understood themselves to be in charge of the programme, while the study area directors provided only "technical assistance." By the end of the project, however, this had been explicitly reconceived as "technical cooperation."²⁸ No longer mere assistants to the WHO officers, the study area directors were now seen as "provid[ing] the Organization with a referral network of professional authority and wisdom."²⁹ Increasingly, policy-relevant expertise was now seen to be distributed across a network of practitioners, and not just centralised in WHO's European office. This flattening out of authority relations was also apparent in the way that changes were made to local mental health provision primarily as a result of mutual learning and reflection among the participants themselves, while the role of the WHO Europe office in directing or mandating them appears to have been limited.

This approach to policy was particularly evident in the events surrounding the 2005 Ministerial Conference in Helsinki and the launch of the Mental Health Declaration and Action Plan.³⁰ As the architects of the conference were aware, any Europe-wide mental health policy would have to be applicable across a diverse range of contexts, from the relatively specialised, community-based mental health services found in Scandinavia, the UK, Germany and the Netherlands, to the much more basic, institutionally-based psychiatric services found elsewhere in Europe. Hence the decision to eschew strongly prescriptive and standardised guidelines that would be difficult to apply across such different situations, and instead to use the Declaration

and Action Plan to reassert the general values and principles of community mental health. More specific suggestions for action were represented in the accompanying briefing documents in the form of exemplary cases of good practice that national policymakers and practitioners could adapt to their own local needs.³¹ In compiling these briefing documents, WHO Europe again mobilised its network of local experts, expanded now to include not just academics and practitioners but also "experts by experience"—notably mental health service users—bringing them together in a series of pre-meetings to select examples that best reflected the values and principles represented in the Declaration and Action Plan.

Subsequent efforts to implement those values and principles in mental health practice likewise revolved primarily around face-to-face meetings and reflection on local needs. In the wake of the Helsinki conference, WHO Europe sponsored a series of conferences and meetings in member countries, co-chaired by WHO and an in-country host organization. Sometimes the Regional Adviser on Mental Health would be present to outline the principles set out in the Declaration and Action Plan, while the national counterpart would respond with a discussion of the particular situation that obtained in the host country. As one of our respondents recalled, this juxtaposition of general principles with local particularities, although "a very imprecise process", nonetheless provided a means of stimulating local policy development.³² Other meetings served primarily as opportunities for sharing best practice, providing "technical assistance", and "pressing and cajoling" local policy makers and practitioners, as another of our respondents put it.³³ Here too, however, the power to decide exactly how WHO policies should be put into practice remained very much in the hands of local policy makers and practitioners. Local and national

policy makers were at liberty, should they so wish, to appropriate WHO policy initiatives in ways that bore little resemblance to WHO Europe's vision of community mental health—as happened for instance when Hungarian psychiatrists invoked the Mental Health Declaration for Europe to legitimise and reinforce their own preferred institutional and professional authority structures.³⁴

In working this way, then, policy makers come to know their domain of action through collective reflection on the meaning of exemplary cases, and informed consideration of how those cases might be emulated locally. But exemplary cases are brought into relief and their significance made clear only in relation to other cases: through comparison. Such comparison may be explicit or, more often, implicit. But it is typically an open-ended, mutualistic way of knowing and ultimately of acting, negotiated in meetings of knowledgeable practitioners—not authoritarian and prescriptive, but collaborative, exploratory and adaptive.

Conducting surveys

Let us turn now to consider the efforts that WHO Europe has made since the early 1970s to conduct more explicitly comparative, systematic surveys of mental health provision in its member countries. Given the difficulties that the Organisation and its officials experienced in executing such surveys, and their continuing failure to deliver a strictly comparative analysis of mental health provision, it is tempting to suppose that their efforts in this direction were simply wasted. Again, this would be to misunderstand what happens in the work of comparison, and the role it plays in policy work more generally. Certainly, none of those involved in the surveys took the view

that they had been a waste of time. Commenting on May's first survey, for instance, his successor as Regional Adviser took the view that while the findings did not permit strict comparison, they were nonetheless informative: "A series of imprecise yet recognizable patterns had emerged, which could provide the basis for future policy statements and inquiries."³⁵ How are we to understand this? If a survey fails to deliver strictly comparative data, how might it nonetheless contribute to the production of useful policy knowledge and to the formulation and implementation of policy?

Surveys, too, involve knowledge of cases—but they proceed in a very different way. Rather than allowing the axes of comparison to emerge inductively, in the course of open-ended discussion, surveys begin by defining in advance what aspects of cases will be compared. And it was this that proved so difficult in WHO Europe's attempts to survey mental health provision across its member countries. In many instances, the categories of knowledge or data specified in the survey instruments proved to be inapplicable to the local reality of particular mental health care systems; and even where they could be applied, the data often proved not to exist, or were only patchily available. As a result, the surveys consistently failed to produce the kind of standardised data that would support strictly deductive comparison between cases. That did not mean that the surveys did not permit any kind of comparison at all, however. While the data they produced were patchy and inconsistent, they were nonetheless sufficient to enable researchers to identify elements of similarity and difference between different cases—to support a more inductive approach to comparison. It was this kind of inductive reasoning that enabled WHO researchers to identify the "imprecise yet recognizable patterns" which "emerged" from May's survey,³⁶ even when that survey failed to produce strictly comparable data. Moreover,

the kinds of data generated by the WHO surveys were not necessarily confined to what was specified in the survey instruments. When Henderson and his colleagues came to analyse their own, similarly patchy survey results, they also incorporated supplementary data, corrections, amendments and discussions that had subsequently been provided by colleagues in member countries;³⁷ in this instance, the survey findings were informed as much by inductive reasoning from local knowledge of particular cases as by strict deduction from standardised data.

The work of conducting surveys is thus not simply a matter of generating the kind of standardised data from which deductive conclusions can be drawn; nor is it solely about the imposition of a centralised, top-down way of knowing and comparing. While survey designers may typically aim to generate this kind of knowledge, the development and conduct of a survey is in many cases directly informed by inductive reasoning from in-depth experience of local cases. Strict, systematic comparison, in other words, is frequently only made possible by prior comparative work of a much more informal kind. Moreover, later surveys often learn from and build on earlier ones. Thus the baseline survey was in part designed to remedy some of the shortcomings of Henderson's study, which was in turn explicitly informed by the difficulties encountered by May's survey. Where we find repeated attempts to survey the same domain of policy activity, then, there may be good reason to think of such attempts as involving an incremental process of exploration, as WHO officers sought by trial and error to determine the most useful categories for generating comparative data.

At the same time, the work of conducting a survey may in some cases actually help to make the domain under investigation more amenable to standardised comparison. Though the data produced by May's survey were not strictly comparable, for instance, he subsequently noted that the countries involved had in many cases gone to considerable lengths in repeatedly checking information available to them, and in some instances undertaking specific, new information-gathering exercises. "Besides disclosing to countries themselves the gaps and deficiencies in their basic data," he observed, "the personal contact with administrators and statisticians which was entailed by the survey has stimulated their efforts to improve their mental health information systems."³⁸ This informal process of education had in some instances led to more formal training: "A practical result of the present survey has been the organization of an annual series of courses on the collection, interpretation and application of mental health statistics, attended by psychiatrists, statisticians and administrators, and designed to explore the use of statistics in monitoring and planning for services."³⁹ In reflecting on the outcomes of their own survey, Henderson and his colleagues observed that this was one of the specific strengths of WHO's efforts in the field of mental health policy: "In particular, the improved collection of information on mental health services is an activity deserving collaboration, for which WHO is the most appropriate international agency."⁴⁰ The baseline study of 2006 to 2008 marked another step in the same direction. Under the baseline study, data collection involved "a partnership process" or "dialogue"⁴¹ between the central research team and the country partners, which had an educative as much as a supervisory function: "As a side effect some countries discovered how to collect data for themselves," reported one of our respondents.⁴² As a result, the kind of data about mental health provision that are routinely produced in different

countries have become more standardised, and hence more comparable, than ever before.

In this regard, the work of conducting surveys may often be performative, in the sense that the very act of doing comparison may result in improvement in the degree of comparability of the phenomena being studied. Successive surveys have led to increasing standardisation of national information systems, as member countries have converged around a common interest in international comparison.⁴³ In so doing, they have conferred a significant measure of authority on WHO Europe itself. In effect, the Regional Adviser's office has been granted the power to determine the categories according to which national mental health systems should be observed, measured and compared, and hence how they should be organised and what values and aims they should embody. As one of our respondents put it: "These are very simplistic and yet authoritative ways of recording what you're about and what you're expecting to be about."⁴⁴

So what do WHO's assembled experts now know of mental health in Europe, and how do they know it? The survey, like the Pilot Area Studies and more ad hoc discussion of different national arrangements, is a form of comparison involving cases. It is a special case of case-based comparison more generally, and one which seems to entail different kinds of social and political relations. What is special about surveys is that they require and reflect a unitary, authoritative capacity to fix the terms of comparison: a top-down strategy that favours a more centralised, hierarchical production of knowledge than the flatter relationships implied in a more inductive case-based approach. Nevertheless, as this section has shown, the making of

comparison still turns to a considerable extent on the collaboration of national and local partners in agreeing and even determining what kinds of parameters may be observed in comparing one country with another. Survey criteria are themselves informed by inductive, case-based knowledge of local circumstances; while authoritative comparison is only achieved with the active participation of those subject to it.

Conclusion

Surveys and case studies are often treated as dichotomous: as distinct epistemologies producing very different kinds of knowledge. Here, in our study of WHO, we have tried to show that they are actually instances of the same thing—of comparison—and that the relationship between them is intricate and sustained. While they clearly differ, that difference is one of degree, not of kind; surveys and case studies differ in the emphasis they place on different kinds of work, and in the way that work is organized. In both cases, knowledge is a collective achievement of knowledgeable actors; and in both cases, comparability is negotiated with others, in the back-and-forth of data-gathering and discussion, judged according to the standards emergent in those interactions. Our history of knowledge production at WHO is thus one of cases and surveys, but it is also a story of meetings—of seminars, working groups and countless other, less formal occasions at which both surveys and case studies were collectively conceived, problematized and debated. At the same time, the conduct and outcomes of those meetings was conditioned by the wider social and political relations within which they took place, while the different kinds of comparison they enacted reflected, reproduced and sometimes subtly shifted those relations. Seen in this light, the

emergence and consolidation of the cross-national survey within WHO was itself political—a centralizing move, which served to establish WHO as a key actor in determining what would count as the best knowledge for policy, and hence in the work of policy itself.

¹ For instance, Giovanni Sartori, “Concept Misformation in Comparative Politics,” *American Political Science Review* 64 no. 4 (1970): 1033-1053; Arend J. Lijphart, “Comparative Politics and the Comparative Method,” *American Political Science Review* 65 no. 3 (1971): 682-693; and for a fundamental critique, Alastair MacIntyre, “Is a Science of Comparative Politics Possible?” in *Against the Self-Images of the Age* (London: Duckworth, 1971).

² Richard Freeman and Eric Mangez, “For a (Self-)Critical Comparison,” *Critical Policy Studies* 7 no. 2 (2013): 198-206.

³ For instance Peter M. Haas, “Introduction: Epistemic Communities and International Policy Coordination,” *International Organization* 46 no. 1 (1992): 1–35.

⁴ Sheila Jasanoff, *States of Knowledge: The Co-Production of Science and the Social Order* (London: Routledge, 2004). See also Richard Freeman and Steve Sturdy (eds), *Knowledge in Policy: Embodied, Inscribed, Enacted* (Bristol: The Policy Press and Chicago: University of Chicago Press, 2014).

⁵ This narrative is recounted at greater length in Steve Sturdy, Richard Freeman and Jennifer Smith-Merry, “Making Knowledge for International Policy: WHO Europe

and Mental Health Policy, 1970-2008," *Social History of Medicine* 26 no.3 (2013): 532-554.

⁶ World Health Organization, *WHO and Mental Health 1949-1961* (Geneva: WHO, 1962).

⁷ *Ibid.*, 6.

⁸ *Ibid.*

⁹ WHO Europe, *Sixty Years of WHO in Europe* (Copenhagen: WHO Regional Office for Europe, 2009), 20; Hugh L. Freeman, Tom Fryers and John H. Henderson, *Mental Health Services in Europe: 10 Years On* (Copenhagen: World Health Organization Regional Office for Europe, 1985), 2.

¹⁰ Anthony May, *Mental Health Services in Europe. A Review of Data Collected in Response to a WHO Questionnaire* (Geneva: WHO, 1976), 1.

¹¹ *Ibid.*, 1-2.

¹² Freeman, Fryers and Henderson, *Mental Health Services in Europe: 10 Years On*, 4, 29-30.

¹³ *Ibid.*, 71.

¹⁴ Sturdy, Freeman and Smith-Merry, "Making Knowledge for International Policy," 542-3.

¹⁵ Michelle Funk, Natalie Drew and Benedetto Saraceno, "Global Perspective on Mental Health Policy and Service Development Issues: The WHO Angle," in *Mental Health Policy and Practice across Europe. The Future Direction of Mental Health Care*, ed. Martin Knapp, David McDaid, Elias Mossialos and Graham Thornicroft (European Observatory on Health Systems and Policies Series, Maidenhead: Open UP, 2007), 426-440; Shekhar Saxena, Antonio Lora, Mark van Ommeren, Thomas Barrett, Jodi Morris and Benedetto Saraceno, "WHO's Assessment Instrument for

Mental Health Systems: Collecting Essential Information for Policy and Service Delivery,” *Psychiatric Services* 58 no. 6 (2007): 816–821.

¹⁶ WHO Europe, *Policies and Practices for Mental Health in Europe—Meeting the Challenges*, (Copenhagen: WHO Regional Office for Europe, 2008), 89.

¹⁷ WHO Europe, *Changing Patterns in Mental Health Care. Report on a WHO Working Group*, Cologne, 27 November - 1 December 1978 (Copenhagen: WHO Regional Office for Europe, 1980).

¹⁸ Phase I of the project (1973-1974) was concerned with collating existing information on information systems, demographic and socioeconomic patterns, service provision and numbers of current patients. Phase II consisted in cohort studies and some preliminary evaluation (1975-1977); phase III, beginning in 1978, included all the areas already involved with the addition of another ten. Each agreed to provide an area description, an inventory of services, a patient census and a cohort study.

¹⁹ WHO Europe, *Changing Patterns in Mental Health Care*, 2.

²⁰ WHO Europe, *Mental Health in Europe. Country Reports from the WHO European Network on Mental Health* (Copenhagen: WHO Regional Office for Europe, 2001), i.

²¹ WHO Europe, *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions*, 2005, WHO EUR/04/5047810/6; WHO Europe, *Mental Health Action Plan for Europe: Facing the Challenges, Building Solutions*, 2005, WHO EUR/04/5047810/7.

²² WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study*, (Copenhagen: WHO Regional Office for Europe, 1987), vii.

²³ D. Walsh, "Mental health services models in Europe," in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study* (Copenhagen: WHO Regional Office for Europe, 1987), 53-75, at 73.

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- ²⁴ Hugh Freeman and Thomas Fryers, "The Pilot Areas Study and the Context of Mental Health Care," in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study* (Copenhagen: WHO Regional Office for Europe, 1987), 147-160, at 157.
- ²⁵ Walsh, "Mental Health Services Models in Europe," 73.
- ²⁶ Robert Giel and J. U. Hannibal, "From Phases I and II to Phase III," in WHO Europe, *Mental Health Services in Pilot Study Areas. Report on a European Study* (Copenhagen: WHO Regional Office for Europe, 1987), 7-11, at 9, 11.
- ²⁷ Walsh, "Mental Health Services Models in Europe," 74; Freeman and Fryers, "The Pilot Areas Study," 160.
- ²⁸ WHO Europe, *Mental Health Services in Pilot Study Areas*, vii.
- ²⁹ *Ibid.*, viii.
- ³⁰ These events are discussed in more detail in Sturdy, Freeman and Smith-Merry, "Making Knowledge for International Policy," 545-547.
- ³¹ These documents are analysed at length in Richard Freeman, Jennifer Smith-Merry and Steve Sturdy, WHO, Mental Health, Europe. Know&Pol Project Report, 2009, available online at <http://knowandpol.eu/IMG/pdf/o31.who.fabrication.pdf>.
- ³² Interview, 18 November 2008.
- ³³ Interview, 3 March 2008.
- ³⁴ Bori Fernezelyi and Gabor Eröss, "Knowledge Interests: Promoting and Resisting Change in Mental Health in Hungary," in *Knowledge in Policy: Embodied, Inscribed, Enacted*, ed. Richard Freeman and Steve Sturdy (Bristol: Policy Press, 2015), 143-158.

³⁵ Freeman, Fryers and Henderson, *Mental Health Services in Europe: 10 Years On*, 27.

³⁶ Freeman, Fryers and Henderson, *Mental Health Services in Europe: 10 Years On*, 27.

³⁷ *Ibid.*, 2-3.

³⁸ May, *Mental Health Services in Europe*, 57.

³⁹ *Ibid.*

⁴⁰ Freeman, Fryers and Henderson, *Mental Health Services in Europe: 10 Years On*, 4.

⁴¹ WHO Europe, *Policies and Practices for Mental Health in Europe*, 6; interview, 18 November 2008.

⁴² Interview, 18 November 2008.

⁴³ Cf. Sotiria Grek, "Governing by Numbers: The PISA 'Effect' in Europe," *Journal of Education Policy* 24 no. 1 (2009): 23–37.

⁴⁴ Interview, 30 July 2008.